STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155654	B. WING		06/21/2012	
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE		
				NGLE RD		
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER	FORT	WAYNE, IN 46809		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This wisit was fo	on the investigation of	F0000	The following Plan of Correction	on	
		or the investigation of	1 0000	constitutes our written allegati		
	complaint IN00	110319.		of compliance for the deficient	l l	
	C 1: A DIOC)110210 G 1 + 1		cited. Submission of the Plan		
		0110319- Substantiated		Correction is not an admission		
		ate deficiencies related to		that a deficiency exists or that one was cited correctly. This		
	1 -	eited at F-225, F-226, and		Plan of Correction is submitted	d to	
	F-309.			meet requirements established		
				by state and federal law.		
	Survey date: 6/2	21/12				
	Facility number					
	Provider numbe					
	AIM number: 10	00266110				
	Survey team:					
	Tim Long, RN-	TC				
	Susie Scott, RN					
	Julie Wagoner,					
	Christine Fodre	a, RN				
	Census bed type	2 :				
	SNF/NF: 61					
	Total: 61					
	Census Payor ty	pe:				
	Medicare: 2					
	Medicaid: 46					
	Other: 13					
	Total: 61					
	Sample: 3					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000498

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/21/	ETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		2237 EN	DDRESS, CITY, STATE, ZIP CODE NGLE RD VAYNE, IN 46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		es reflect state findings ace with 410 IAC 16.2.					
	Quality review c 2012 by Bev Fau	ompleted on June 25, alkner, RN					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 2 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155654	B. WIN			06/21/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				NGLE RD		
ENICI EW		EHABILITATION CENTER			VAYNE, IN 46809		
LINGLEV	OODTIEALITIAR	ELIABILITATION CENTER		FORT	VATNE, IN 40009		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225	483.13(c)(1)(ii)-(i	iii), (c)(2) - (4)					
SS=D	INVESTIGATE/F						
	ALLEGATIONS/						
		not employ individuals who					
		I guilty of abusing,					
		streating residents by a court					
		ad a finding entered into the					
		registry concerning abuse, ment of residents or					
		of their property; and report					
		t has of actions by a court of					
		mployee, which would					
	•	s for service as a nurse aide					
		taff to the State nurse aide					
	registry or licens						
	3						
	The facility must	ensure that all alleged					
	violations involvi	ng mistreatment, neglect, or					
		injuries of unknown source					
		ation of resident property are					
		ately to the administrator of					
	•	o other officials in accordance					
		rough established					
		uding to the State survey and					
	certification ager	icy).					
	The facility much	have evidence that all					
		have evidence that all s are thoroughly investigated,					
	-	it further potential abuse					
		gation is in progress.					
	Willio the investig	gation to in progress.					
	The results of all	investigations must be					
		dministrator or his					
	•	esentative and to other					
	•	dance with State law					
	(including to the	State survey and certification					
	agency) within 5	working days of the incident,					
		d violation is verified					
	appropriate corre	ective action must be taken.					
			F02	25	The facility is unable to correct		07/21/2012
	Based on intervie	ew and record review, the			the alleged deficient practice for		
	Zasca on micryli				resident C as it occurred in the	:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet Page 3 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMI		COMPL	ETED	
		155654	B. WIN			06/21/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			NGLE RD		
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER			WAYNE, IN 46809		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	_	TAG			DATE
	· ·	ensure residents were			past. All residents have the potential to be affected by the		
	protected from potential further abuse during an investigation of abuse and				alleged deficient practice. Ale		
					residents and family members will		
	failed to thoroughly document the				be interviewed to ensure no o		
	investigation for	1 of 3 residents			residents have been affected	by	
	(Resident C) rev	riewed for abuse.			the alleged deficient practice.		
	Findings include:				Resident and family member interviews will continue for 15		
					residents at random every thr	ee	
					months ongoing. Administrate		
	 Resident C's clir	nical record was reviewed			audit interviews after completi		
	on 6/21/12 at 9:30 A.M. The record indicated on 1/6/12 at 12:30 A.M., an incident occurred in which the resident				Audit results to be discussed		
					QA Committee meetings. State	-	
					rein-service conducted 6/26/1 facility abuse policy and the	2 011	
					Indiana Reportable Unusual		
		‡1 treated her roughly			Occurrence Guidelines.		
		her up after using the bed			ADDENDUM:1. Staff inservice	9	
	pan.				held 6/26/12 instructing nursir	-	
					notify HFA immediately with a	•	
		lity incident report from			allegations of abuse. HFA will ensure Preliminary	ı	
	1/6/12 at 1:30 P.	M., indicated "Resident			Investigation is initiated, which	า	
	stated to LPN or	n the night shift that the			includes a task of immediate		
	CNA had wiped	her too hard when			suspension of alleged employ	ee	
	cleaning her up	from using the bed pan."			pending investigation.2. The	I II	
	The immediate a	action taken was the LPN			Internal Investigation Report s be updated to include all area		
	had the other CN	NA that was working take			investigation have been	3 01	
		are for Resident C and			completed according to policy		
		N. The preventive					
		were: "Investigation					
		Services notified.					
		egation was found to be					
		Preventive Measures:					
		n question no longer care					
		resident, and we will					
		nbers to care for resident					
	with activities of	f daily living."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet Page 4 of 15

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155654	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 06/21 /	ETED	
	PROVIDER OR SUPPLIER VOOD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	The facility documentation of the investigation of the incident of 1/6/12 involving Resident C and CNA #1 included a statement by LPN #2 who indicated the resident stated to her CNA #1 got the resident off the bed pan and wiped her buttocks too hard. The resident also indicated she didn't feel comfortable with the aide wiping her because she felt more of the aide's fingers than tissue. The resident stated she didn't have a bowel movement and didn't need or want wiped. LPN #2 indicated she spoke with CNA #1 who indicated Resident C had a bowel movement and needed to be cleaned up. The facility documentation of the investigation of the incident of 1/6/12 involving Resident C also contained an internal investigation report by the Director of Nursing (DN) which indicated the DN interviewed the resident on 1/6/12 at 7:30 A.M. The resident stated: "The CNA was cleaning her up from using the bed pan and that she had only urinated, but the CNA wiped around her rectal area and she then went on to state she felt his finger enter her rectum and then he did it a second time and she felt he did it on purpose." The facility investigation included interviews with two alert and oriented					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 5 of 15

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION 00	СОМ	E SURVEY PLETED
		155654	A. BUILDING B. WING		06/2	1/2012
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	2237	ET ADDRESS, CITY, STATE, ZII 7 ENGLE RD 1T WAYNE, IN 46809	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	was working at 1/6/12. The fact indicated they sporiented residented residented residents of the include names of residents or staff. CNA #1 was not after LPN #1 was accusation on 1/4 allowed to work the facility on 1/4 suspended during allegation of about incident reporting ISDH on 1/6/12 follow-up invest ISDH on 1/6/12 the allegation of unsubstantiated. An interview with at 2:15 P.M., incompared to the process of the control of the c	t suspended immediately as made aware of the 6/12. CNA #1 was with other residents in 6/12. CNA #1 was not g the investigation of the ase on 1/6/12. The facility ag form was faxed to at 1:30 P.M. The digation was faxed to at 3:30 P.M., indicating abuse was the the resident on 6/21/12 dicated the resident was this finger up into her at C indicated she was not a because they always to do her care since the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet Page 6 of 15

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 06/2	e survey pleted 1/2012	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD				
ENGLEW		REHABILITATION CENTER	FORT WAYNE, IN 46809				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
140	3.1-28(d)	ESC IDENTIFIED INFORMATION)				DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 7 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155654		A. BUILDI B. WING	NG	NSTRUCTION 00	(X3) DATE (COMPL 06/21/	ETED	
	PROVIDER OR SUPPLIE VOOD HEALTH & I	REHABILITATION CENTER			NGLE RD VAYNE, IN 46809		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0226 SS=D	ETC POLICIES The facility mus written policies mistreatment, n residents and m property. Based on record facility failed to for abuse related resident and pro following an all residents (C) rev Findings include Resident C's clin on 6/21/12 at 9: indicated on 1/6 incident occurre indicated CNA; during cleaning pan. Review of a fact 1/6/12 at 1:30 P stated to LPN of CNA had wiped cleaning her up The immediate is had the other CN over providing of	t develop and implement and procedures that prohibit eglect, and abuse of hisappropriation of resident. I review and interview, the implement their policy of to assessment of a tection of the resident egation of abuse for 1 of 3 viewed for abuse.	F0226		The facility is unable to correct the alleged deficient practice for resident C as it occurred in the past. All residents have the potential to be affected by the alleged deficient practice. Aler residents and family members be interviewed to ensure no ot residents have been affected to the alleged deficient practice. Resident and family member interviews will continue for 15 residents at random every three months ongoing. Administrator audit interviews after completic Audit results to be discussed a QA Committee meetings. Staff rein-service to be conducted of facility abuse procedures and investigative guidelines. ADDENDUM:1. An abuse polic checklist will be intiated for all nurses to utilize when an allegation of abuse occurs.	t will her by	07/21/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 8 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155654	B. WIN			06/21/2	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ENGLEV	VOOD HEALTH & E	REHABILITATION CENTER			NGLE RD VAYNE, IN 46809		
			<u> </u>		VATNE, IN 40009	<u> </u>	(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	measures taken	were: "Investigation					
		Services notified.					
	Conclusion: Alle	egation was found to be					
	unsubstantiated.	Preventive Measures:					
	will have CNA i	n question no longer care					
	for above stated	resident, and we will					
	have 2 staff men	nbers to care for resident					
	with activities of	f daily living."					
	The facility docu	umentation of the					
	investigation of the incident of 1/6/12						
	involving Resident C and CNA #1						
	included a statement by LPN #2 who						
		ident stated to her CNA					
	_	ent off the bed pan and					
	•	eks too hard. The resident					
		ne didn't feel comfortable					
		g her because she felt					
		's fingers than tissue. The					
		he didn't have a bowel					
		lidn't need or want wiped.					
		d she spoke with CNA #1					
		esident C had a bowel					
	movement and n	needed to be cleaned up.					
	The facility do	amontation of the					
	1	umentation of the					
	_	the incident of 1/6/12 ent C also contained an					
	_	ation report by the					
	_	sing (DN) which indicated					
		wed the resident on 1/6/12					
		ne resident stated: "The					
		ng her up from using the					
		she had only urinated,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 9 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155654			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2012
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	2237 E	ADDRESS, CITY, STATE, ZIP CODE NGLE RD WAYNE, IN 46809	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and she then we	need around her rectal area int on to state she felt his rectum and then he did it and she felt he did it on			
	interviews with residents on the was working at 1 1/6/12. The faci indicated they sporiented resident spoke with other allegation. The i	estigation included two alert and oriented unit on which CNA #1 the time of the incident of lity investigation also poke with other alert and its on the hallway and estaff concerning the investigation did not of any of the other			
	physical exam o allegation or any	on was noted of a f the resident after the type of examination was e resident after the 12.			
	after LPN #1 wa accusation on 1/ allowed to work the facility on 1/ suspended durin allegation of abu incident reportin ISDH on 1/6/12	ts suspended immediately as made aware of the 6/12. CNA #1 was with other residents in 6/12. CNA #1 was not g the investigation of the use on 1/6/12. The facility ag form was faxed to at 1:30 P.M. The igation was faxed to			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 10 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155654			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE NGLE RD	
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER		WAYNE, IN 46809	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	ISDH on 1/6/12 the allegation of unsubstantiated.				
	at 2:15 P.M., inc sure CNA #1 pu rectum. Residen afraid of CNA #	th the resident on 6/21/12 dicated the resident was this finger up into her t C indicated she was not 1 because they always do her care since the 2.			
	Neglect, Misapp Property, dated Interpretation an included: "Section be assessed imm	acility policy, "Abuse, propriation of Resident 1/2012 under Policy and Implementation ion 8. All residents will nediately by the attending facation of alleged abuse, reatment."			
	sustains injury b employee is a su employee must l	indicated: "If the resident by an employee or aspected perpetrator:iii. be sent home (suspended) ading outcome of final			
	This Federal Tag IN00110319	g relates to Complaint			
	3.1-28(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 11 of 15

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ENGLEWOOD HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION (CACH CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING (CACH CORRES, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809 STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809 (X4) ID PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. BUILDING B. WING (CACH CORRECTION STATE) (CACH CORRECTION DEFICIENCY) STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809 (X5) COMPLETION DATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ENGLEWOOD HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCE TO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION COMPLE	ANDILAN	OF CORRECTION		A. BUILDING	00	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) 2237 ENGLE RD FORT WAYNE, IN 46809 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE					ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	NAME OF F	PROVIDER OR SUPPLIE	R			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ENGLEV	VOOD HEALTH & I	REHABILITATION CENTER	FORT	WAYNE, IN 46809	
CROSS-REFERENCED TO THE APPROPRIATE					PROVIDER'S PLAN OF CORRECTION	
					CROSS-REFERENCED TO THE APPROPRIA	IE I
	1.10	ALGOLITOR O	RESC IS EXTENDED ON THE OTHER PROPERTY.	1110		3.112

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet Page 12 of 15

STATEMENT OF DEFICIENCIES		(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
		155654	B. WING		06/21/2012		
NAME OF D	DROVIDED OD SUDDUJED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			2237 ENGLE RD				
ENGLEWOOD HEALTH & REHABILITATION CENTER			FORT WAYNE, IN 46809				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(XS	<i>'</i>
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLE DATE	
		LSC IDENTIFFING INFORMATION)		TAG	BELLEEU.	DAT	E.
F0309 SS=D	483.25 PROVIDE CARE WELL BEING Each resident me must provide the services to attain practicable physical psychosocial well the comprehensicare. Based on record facility failed to assessment follow abuse for 1 residents reviewed. Findings include Resident C's clin on 6/21/12 at 9:3 indicated on 1/6/incident occurred indicated CNA # during cleaning from the immediate at had the other CNA incident occurred indicated to LPN on CNA had wiped cleaning her up for the immediate at had the other CNA incident CNA incident occurred indicated to LPN on CNA had wiped cleaning her up for the immediate at had the other CNA incident CNA incident occurred indicated to LPN on CNA had wiped cleaning her up for the immediate at had the other CNA incident CNA incident occurred indicated to LPN on CNA had wiped cleaning her up for the immediate at had the other CNA incident occurred indicated to LPN on CNA had wiped cleaning her up for the immediate at had the other CNA incident occurred indicated to LPN on CNA had wiped cleaning her up for the immediate at had the other CNA incident occurred indicated indica	e/SERVICES FOR HIGHEST ust receive and the facility necessary care and nor maintain the highest ical, mental, and ill-being, in accordance with ive assessment and plan of review and interview, the complete a physical wing an allegation of ent (Resident C) of 3 ed for abuse. : ical record was reviewed 0 A.M. The record 12 at 12:30 A.M., an d in which the resident 11 treated her roughly ner up after using the bed lity incident report from M., indicated "Resident the night shift that the her too hard when from using the bed pan." ction taken was the LPN IA that was working take	F03		The facility is unable to correct the alleged deficient practice for resident C as it occurred in the past. All residents have the potential to be affected by the alleged deficient practice. Aler residents and family members be interviewed to ensure no ot residents have been affected by the alleged deficient practice. Resident and family member interviews will continue for 15 residents at random every three months ongoing. Administrator audit interviews after completic Audit results to be discussed a QA Committee meetings. Staff rein-service to be conducted of facility abuse procedures and investigative guidelines. ADDENDUM:1. Abuse policy checklist will include a physical resident assesment task.	or 07/21/ will her by e to on. t	
	over providing cannotified the DON	are for Resident C and J.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet Page 13 of 15

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155654	A. BUILDING B. WING	00	COMPLETED 06/21/2012		
NAME OF PROVIDER OR SUPPLIER ENGLEWOOD HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
	The facility documentation of the investigation of the incident of 1/6/12 involving Resident C and CNA #1 included a statement by LPN #2 who indicated the resident stated to her CNA #1 got the resident off the bed pan and wiped her buttocks too hard. The resident also indicated she didn't feel comfortable with aide wiping her because she felt more of the aide's fingers than tissue. The resident stated she didn't have a bowel movement and didn't need or want wiped. LPN #2 indicated she spoke with CNA #1 who indicated Resident C had a bowel movement and needed to be cleaned up. The facility documentation of the investigation of the incident of 1/6/12 involving Resident C also contained an internal investigation report by the Director of Nursing (DN) which indicated the DN interviewed the resident on 1/6/12 at 7:30 A.M. The resident stated: "The CNA was cleaning her up from using the bed pan and that she had only urinated, but the CNA wiped around her rectal area and she then went on to state she felt his finger enter her rectum and then he did it a second time and she felt he did it on purpose." An interview with the resident on 6/21/12 at 2:15 P.M., indicated the resident was					
1	at 2.15 1.141., indicated the resident was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 14 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155654		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2012			
NAME OF PROVIDER OR SUPPLIER ENGLEWOOD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	sure CNA #1 put rectum. Resident afraid of CNA # have two people incident of 1/6/1. No documentation physical exam of allegation or any completed of the incident on 1/6/1. Review of the fan Neglect, and Mis Resident's Prope section "Policy I Implementation, residents will be the attending nur alleged abuse, no	this finger up into her t C indicated she was not a because they always to do her care since the 2. On was noted of a fithe resident after the type of examination was resident after the 2. cility policy "Abuse, sappropriation of try" from 01/2012 under interpretation and "included "Section 8: All assessed immediately by see upon notification of eglect or mistreatment."			CROSS-REFERENCED TO THE APPROPRIA	ATE		
	This Federal Tag IN00110319. 3.1-37(a)	relates to Complaint						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 43L511

Facility ID: 000498

If continuation sheet

Page 15 of 15